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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17181
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 20563

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. 3		d. STREET ADDRESS 317 Morton Street	
3. NAME OF DECEASED (Type or print) First Middle Last JULIA ROUSE ADKINS		4. DATE OF DEATH Month Day Year December 29 1965	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Mary Adkins, Pocomoke City, Md.		Address R.F.D. 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Acute Pulmonary Edema (b) Arteriosclerotic Heart Disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Incapacitated because of old hip fracture			INTERVAL BETWEEN ONSET AND DEATH Few Hours
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE David Rafat		22. DATE SIGNED 12/30/65	
EXAMINER'S NAME (Type) DAVID RAFAT		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-1-1966	23c. NAME OF CEMETERY Klej Grange Methodist	23d. LOCATION (City, town or county) (State) Worcester County, Md.
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR JAN 3 1966	
ADDRESS Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17182 Item #13-14-111-12/23/65 pc 20564											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Snow Hill c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Snow Hill d. STREET ADDRESS Rural, Snow Hill e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last John W. Ashby						4. DATE OF DEATH Month Day Year December 9 19 65					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/6/90		9. AGE (in years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Truck Farm				11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown/ John Ashby						14. MOTHER'S MAIDEN NAME Unknown/ Mary Francis Woodley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 218 20 2736		17. INFORMANT RFD #2 Georgia Ashby, Snow Hill, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO (b) Years. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 65 , to Dec 9, 1965 , that (I) (we) last saw the deceased alive on Dec 6 19 65 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE DAVID RAFAEL						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/15/65			
22c. PHYSICIAN'S NAME (Type) DAVID RAFAEL						22d. ADDRESS Snow Hill, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/12/65		23c. NAME OF CEMETERY OR CREMATORY Friendship Methodist				23d. LOCATION (City, town or county) (State) Snow Hill, Maryland			
24. FUNERAL DIRECTOR William F. Williams						ADDRESS Snow Hill, Maryland		25a. REC'D BY REGISTRAR DEC 15 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17183
CERTIFICATE OF DEATH

20565

1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BERLIN c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X BERLIN d. STREET ADDRESS POWELLTON AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle ALFRED Last AYRES				4. DATE OF DEATH Month DEC. Day 22 Year 1965			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1909	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 5 Days 12 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER HOTEL OPERATOR SELF EMP.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BERLIN MD				12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME JAMES AYRES				14. MOTHER'S MAIDEN NAME ALICE COFFIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		17. INFORMANT MRS. JAMES AYRES BERLIN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3. This man had an abdominal aneurysm (excised 1 yr ago)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Replaced by heart transplant					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 12-22-65	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 12-22 , 19 65 , that (I) (we) last saw the deceased alive on 12-22 19 65 , and that death occurred at 11:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Frank Lewis				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frank Lewis				22d. ADDRESS Waldorf Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/26/65		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City, town or county) (State) BERLIN MD	
24. FUNERAL DIRECTOR Anne A. Burbage Berlin Md				25a. REC'D BY REGISTRAR DEC 30 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17184

20566

1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN d. STREET ADDRESS 1 WILLIAMS ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First CLAYTON Middle LEWIS Last BAKER				4. DATE OF DEATH Month DEC. Day 10 Year 1965											
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 30, 1895		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Mln.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMER				10b. KIND OF BUSINESS OR INDUSTRY RETIRED				11. BIRTHPLACE (County & State, or foreign country) BERLIN MD				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES BAKER				14. MOTHER'S MAIDEN NAME MARY RICHARDSON											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No				17. INFORMANT DOUGLAS BAKER, BERLIN, MD							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocarditis 431X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Emphysema DUE TO (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Dec 7, 1965 to Dec 10, 1965 , that (I) (we) last saw the deceased alive on Dec 7, 1965 , and that death occurred at 1:06 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Clifford E. Schott M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT MD. BERLIN, MD.												22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12/12/65		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN				23d. LOCATION (City, town or county) (State) BERLIN MD					
24. FUNERAL DIRECTOR Anna A. Burbage Berlin Md												25. REC'D BY REGISTRAR DEC 15 1965		26. REGISTRAR'S SIGNATURE	

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
<div style="display: flex; justify-content: space-between;"> 17185 20567 </div>											
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop c. LENGTH OF STAY IN 1b 35 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XX						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lillie Mae Baker 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 20, 1879 9. AGE (In years last birthday) 86 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.						4. DATE OF DEATH Dec. 18, 1965 19					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME Jimmie Hudson 14. MOTHER'S MAIDEN NAME May Breasure					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX (If yes give war or dates of service) XX 16. SOCIAL SECURITY NO. NO-NUMBER 17. INFORMANT Carl Baker Bishop, Md. Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary 4201 DUE TO (b) Chr. Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) aged INTERVAL BETWEEN ONSET AND DEATH 10 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 10, 1965</u>, to <u>Dec 18, 1965</u>, that (I) (we) last saw the deceased alive on <u>Dec 17, 1965</u>, and that death occurred at <u> </u> M, from the causes and on the date stated above. 22a. SIGNATURE Chas R Law M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12-20-65 22c. PHYSICIAN'S NAME (Type) Berlin 22d. ADDRESS Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12/21/65 23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. 23d. LOCATION (City, town or county) (State) Bishopville, Md.											
24. FUNERAL DIRECTOR Edwin Whaley Selbyville, Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge DATE DEC 22 1965											

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

<div>Item 18 Film G372 12/22/65</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>17186 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 20568</div>											
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>35th St & Ocean</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>WOR</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City - RURAL</u> d. STREET ADDRESS <u>Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARVIN JEFFERSON DERRICKSON</u> First Middle Last						4. DATE OF DEATH <u>Dec 8 1965</u> Month Day Year					
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23 1923</u> Month Day Year		9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bulldozer operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>				11. BIRTHPLACE (State or foreign country) <u>R2 Berlin, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cyrus Derrickson</u>						14. MOTHER'S MAIDEN NAME <u>SARA Stanley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWII</u>						16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS CATHERINE DERRICKSON (WIFE)</u> Address <u>Ocean City Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PENDING / COMPLETION OF AUTOPSY</u> 9125 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO <u>Asphyxia, traumatic, accidental</u> (b) OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>											
MEDICAL CERTIFICATION											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Bulldozer struck beam compressing chest.</u>							
20c. TIME OF INJURY Month, Day, Year <u>11 35 a.m. Dec 8 65</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>35th Street Ocean City</u>		20f. (City or town) <u>WOR</u> (County) <u>Md.</u> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr</u>				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <u>Ocean City Md</u>				22. DATE SIGNED <u>Dec 10, 65</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-12-65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>				23d. LOCATION (City, town or county) (State) <u>Berlin, Md.</u>			
24. FUNERAL DIRECTOR <u>Loretta B. Jolley</u> Address <u>Salisbury</u>						25. REC'D BY REGISTRAR <u>DEC 15 1965</u> DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "diagnosis" and "history" are faintly visible.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17187
CERTIFICATE OF DEATH
20569

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City c. LENGTH OF STAY IN 1b 28 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 406 Market Street				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City d. STREET ADDRESS 1 406 Market Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WEBSTER HAMPTON HOWARD		4. DATE OF DEATH Month Day Year December 20 19 65					
5. SEX Male Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1872				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Lumber	11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia				
13. FATHER'S NAME William Henry Howard		14. MOTHER'S MAIDEN NAME Mary Elizabeth Mason					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-10-6691					
17. INFORMANT Mrs Rebecca Howard, Pocomoke City, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT PRELIMINARY TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 1 Day				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan. 19 49, to Dec. 20 19 65, that (I) (we) last saw the deceased alive on Dec. 20, 19 65, and that death occurred at 11:27 PM, from the causes and on the date stated above.							
22a. SIGNATURE Charles W. Trader		22b. DATE SIGNED 12/21/65					
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.		22d. ADDRESS 302 Market St., Pocomoke, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-22-1965	23c. NAME OF CEMETERY Liberty Cemetery	23d. LOCATION (City, town or county) (State) Parkslay, Virginia				
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE DEC 27 1965					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17188

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

20570

1. PLACE OF DEATH a. COUNTY Worcester		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b Berlin		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Jacobs Last Jacobs				4. DATE OF DEATH Month December Day 22 Year 19 65		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17/10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Co.		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Min. 	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 231033683		17. INFORMANT Cicilia Gatling, Berlin, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular Disease 443+ DUE TO (b) CVA with left hemiparesis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus												INTERVAL BETWEEN ONSET AND DEATH 11 1/2 yrs 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (the physician) attended the deceased from 3/19/54 to 12/21/65 , 19 65 , that (I) (we) last saw the deceased alive on 12/21/65 19 65 , and that death occurred at 7:50 AM M, from the causes and on the date stated above.													
22a. SIGNATURE <i>Ivory U. Sully, Jr.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/24/65			
22c. PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD				22d. ADDRESS P. O. Box 126, Berlin, Md. 21811									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/65		23c. NAME OF CEMETERY OR CREMATORY Petitt Cemetery		23d. LOCATION (City, town or county) (State) Snow Hill, Maryland							
24. FUNERAL DIRECTOR Dennis Funeral Home				ADDRESS Snow Hill, Maryland		25a. REC'D BY REGISTRAR DEC 29 1965		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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PERMIT OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 20571

17189

1. PLACE OF DEATH a. COUNTY Worcester WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STOCKTON		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X STOCKTON			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				1d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last STEWART LABAN JOHNSON				4. DATE OF DEATH Month Day Year DEC. 7 1965			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 26, 1889	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER + WATCHMAN		10b. KIND OF BUSINESS OR INDUSTRY WATCHMAN		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LABAN JOHNSON				14. MOTHER'S MAIDEN NAME ALICE ADAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 230-14-8184		17. INFORMANT Address MRS. LUTHER TRUITT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH FEW MINUTES Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE David Rafat				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) DAVID RAFAT				DATE SIGNED 12/7/65			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/9/65		22c. NAME OF CEMETERY OR CREMATORY PARKSLEY		22d. LOCATION (City, town, or county) (State) PARKSLEY VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry M. Johnson				24a. REC'D BY REGISTRAR DEC 13 1965		24b. REGISTRAR'S SIGNATURE Charles Judge	

STATE OF ALABAMA
DEPARTMENT OF HEALTH - BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE UNIVERSITY OF CHICAGO PRESS

VR A15 (4)
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17190

CERTIFICATE OF DEATH

20572

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Accomac	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbackville 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holland Nurseing Home				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula		First M.		Last Jones	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/2/72		9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 31 Days 1965	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Worcester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Tarr		14. MOTHER'S MAIDEN NAME Irene (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chester Jones, Girdletree, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure 332X DUE TO (b) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov , 19 65 , to Dec , 19 65 , that (I) (we) last saw the deceased alive on Dec 31 19 65 , and that death occurred at 11:30 M, from the causes and on the date stated above.					
22a. SIGNATURE David Rafat		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/3/66	
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT		22d. ADDRESS Snow Hill Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/4/66		23c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery	
23d. LOCATION (City, town or county)		23e. (State)		23f. (Country)	
24. FUNERAL DIRECTOR Charles Judge		24a. ADDRESS Snow Hill, Maryland		24b. REC'D BY REGISTRAR 1 JAN 4 1966	
24c. REGISTRAR'S SIGNATURE Charles Judge		24d. (State)			

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VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City					c. LENGTH OF STAY IN 1b Life					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. 3					d. STREET ADDRESS R.F.D. 3					
3. NAME OF DECEASED (Type or print) First CLARA Middle MAE Last MASON					4. DATE OF DEATH Month December Day 16 Year 1965					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1886		9. AGE (In years last birthday) 79 IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Gordon Redden					14. MOTHER'S MAIDEN NAME Savannah Ward					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT G. Randall Mason, Pocomoke City, Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC ASTHMA (c) ARTERIO SCLEROTIC CARDIAC DIS. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 12/16 , 19 65 , that (I) (we) last saw the deceased alive on 12/16 , 19 65 , and that death occurred at _____ M, from the causes and on the date stated above.										
22a. SIGNATURE Neville A. Baron					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/17/65			
22c. PHYSICIAN'S NAME (Type) NEVILLE A. BARON					22d. ADDRESS Pocomoke, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-19-1965		23c. NAME OF CEMETERY OR CREMATOR First Baptist		23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland				
24. FUNERAL DIRECTOR Robert H. Watson					ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DEC 22 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17192 CERTIFICATE OF DEATH 20574									
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City			c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Belden Restorium					d. STREET ADDRESS R.F.D. 3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last J. FRANK PHILLIPS					4. DATE OF DEATH Month Day Year December 2 1965				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1882		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Phillips					14. MOTHER'S MAIDEN NAME Elizabeth Mason				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Harry W. Phillips, Pocomoke City, Md.			Address R.F.D. 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY OCCLUSION (Presumptive) (b) Arteriosclerosis & atherosclerosis, Senile, gen. (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prior to 1 year ago which included patient for life. Myocarditis, atherosclerosis, etc.								INTERVAL BETWEEN ONSET AND DEATH approx 1 hour many years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10-10, 1947, to 11-2, 1965, that (I) (we) last saw the deceased alive on 11-2, 1965, and that death occurred at 9:50 PM, from the causes and on the date stated above.									
22a. SIGNATURE N.E. Sartorius, Jr.					22b. DATE SIGNED 11-3-65			22c. PHYSICIAN'S NAME (Type) N.E. Sartorius, Jr., M.D.	
22d. ADDRESS 114 Market St., Pocomoke City, Md.					22e. REC'D BY REGISTRAR DEC 6 1965				
22f. REGISTRAR'S SIGNATURE Robert H. Watson					22g. REGISTRAR'S SIGNATURE Charles Judge				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-5-1965		23c. NAME OF CEMETERY First Baptist			23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland	

E. Q. 18

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1985-86

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			c. LENGTH OF STAY IN life Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Willow Street					d. STREET ADDRESS Willow Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOHN		Middle EDWARD		Last PRUITT		4. DATE OF DEATH Month December Day 19 Year 19 65	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 16, 1902		9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Plumbing			11. BIRTHPLACE (State or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Major S. Pruitt					14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-05-5960		17. INFORMANT Address Mrs Gladys Wooster, Pocomoke City, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4281 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Chronic Alcoholism with (c) Anemia								INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE DAVID RAFAI			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22. DATE SIGNED 12-20-65			
EXAMINER'S NAME (Type) DAVID RAFAI			Address (Street, city, town, or county) Pocomoke City, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-1965		23c. NAME OF CEMETERY Salem Methodist			23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland		
24. FUNERAL DIRECTOR Robert H. Wakan					25a. REC'D BY REGISTRAR DEC 27 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

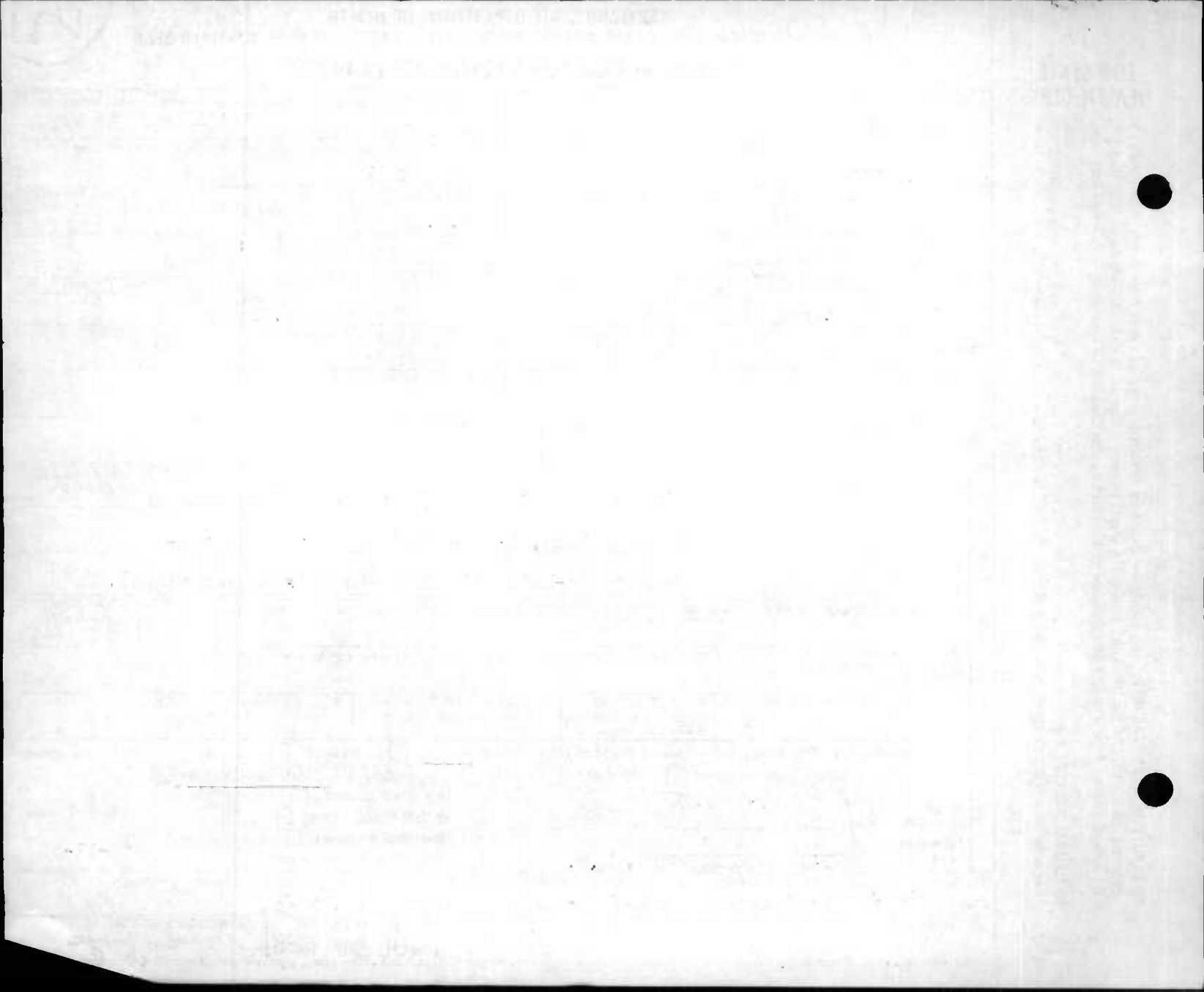
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SNOW HILL c. LENGTH OF STAY IN 1b SNOW HILL d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill d. STREET ADDRESS R.D. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLAD First Middle Last CLAD PURNELL		4. DATE OF DEATH FOUND: 12 3 19 65 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH App. 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Skeleton of old man (Disappeared from home Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) January 10th, 1964 - Skeleton found approxi- (c) mately one-half mile from where last seen alive).			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE RUDIGER BREITENECKER, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 2-11-66	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
CREMATED	12/10/65	Chief Medical Examiner's Office	TBA/To.
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
		DAUL 29 1966	Charles Jones



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17194

CERTIFICATE OF DEATH

20576

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill c. LENGTH OF STAY IN 1b Snow Hill d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 413 S. Church St.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill d. STREET ADDRESS 413 S. Church St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Warren		First I		Middle Pusey		Last Pusey		4. DATE OF DEATH Month December Day 29 Year 1965	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/4/94		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Asbury Pusey				14. MOTHER'S MAIDEN NAME Caroline Pusey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218246009		17. INFORMANT Elsie A. Pusey, Snow Hill, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4213 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO (c) Chronic Pulmonary Insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0082 ASHD Quiescent Tuberculosis								INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 days Yes	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 64 , to Dec , 19 65 , that (I) (we) last saw the deceased alive on Dec 27 19 65 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE David Rafat				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT				22d. ADDRESS Snow Hill, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) B urial		23b. DATE THEREOF 1/1/66		23c. NAME OF CEMETERY OR CREMATORY St. Stephens		23d. LOCATION (City, town or county) (State) Delmar, Del.			
24. FUNERAL DIRECTOR William F. Harris				ADDRESS Snow Hill, Maryland		25a. REC'D BY REGISTRAR JAN 3 1966		25b. REGISTRAR'S SIGNATURE John Charles Jones	

No ----- 218246009 Elsie A. Pusey, Snow Hill, Maryland

- y Pusey

Caroline Pusey

Saw Mill

Somerset Co., Md.

USA

2/4/94

71

Pusey

December 27

413 S. Church St.

W Hill

Worce

Pulmonary tuberculosis
Respiratory tuberculosis

2 R12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
17195					Item #2d F 17195-171306 DE					20577				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					b. COUNTY				
WORCESTER					MARYLAND					WORCESTER				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN ID					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
BERLIN					84 yrs					X BERLIN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
BERLIN NURSING HOME					1 MANH/1877 Boy St.									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
HARRY					TIMMONS					DEC. 28 1965				
5. SEX					6. COLOR OR RACE					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				
M					W					WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH					9. AGE (In years last birthday)					IF UNDER 1 YEAR IF UNDER 24 HRS.				
FEB. 22, 1881					84 yrs.					Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)				
FARMER					RETIRED					BERLIN (RFD) MD				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
U.S.A.					CHARLES TIMMONS					MARGARET DENNIS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No					No					MRS. RAYMOND BUNTING BERLIN MD				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Chr Myocarditis - acute attack DUE TO (b) Chr Nephritis DUE TO (c) Hypertension										INTERVAL BETWEEN ONSET AND DEATH 4 weeks				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19														
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>														
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)														
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from Aug 10 - 1965, to Dec 28 - 1965, that (I) (we) last saw the deceased alive on Dec 27 - 1965, and that death occurred at 9 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Chas R Law														
22b. DATE SIGNED 12-29-65														
22c. PHYSICIAN'S NAME (Type) M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>														
22d. ADDRESS Berlin Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)														
23b. DATE THEREOF														
23c. NAME OF CEMETERY OR CREMATORY														
23d. LOCATION (City, town or county) (State)														
24. FUNERAL DIRECTOR Anna A. Burbage Berlin Md.														
25a. REC'D BY REGISTRAR JAN 3 1966														
25b. REGISTRAR'S SIGNATURE Charles Judge														

80573

DEPARTMENT OF HEALTH

13183

REPORT OF THE
COMMISSIONER OF HEALTH
OF THE STATE OF NEW YORK
FOR THE YEAR 1902
CONTAINING
A SUMMARY OF THE
MORBIDITY AND MORTALITY
IN THE STATE
AND A REPORT ON THE
HYGIENIC CONDITION
OF THE PEOPLE
AND THE
SANITARY CONDITION
OF THE CITIES AND VILLAGES
AND A REPORT ON THE
HYGIENIC CONDITION
OF THE CITIES AND VILLAGES
AND A REPORT ON THE
HYGIENIC CONDITION
OF THE CITIES AND VILLAGES

NEW YORK
1903

PRINTED BY THE
STATE OF NEW YORK
1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
17196						CERTIFICATE OF DEATH						20578	
1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOPVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOPVILLE d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle R. Last TUBBS						4. DATE OF DEATH Month DEC. Day 29 Year 1965							
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 5 1882		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY SELF EMP		11. BIRTHPLACE (County & State, or foreign country) BISHOPVILLE MD				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES R. TUBBS						14. MOTHER'S MAIDEN NAME MARY JULLEN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES						16. SOCIAL SECURITY NO. 1999-19241217-14-8860		17. INFORMANT Mrs. MARY BIRCH				Address OCEAN CITY MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular thrombosis 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) generalized arterio sclerosis DUE TO (c) 17 years												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of urinary bladder													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 27 Dec, 1965 , to 29 Dec, 1965 , that (I) (we) last saw the deceased alive on 27 Dec, 1965 , and that death occurred at 10 a.m. , from the causes and on the date stated above.													
22a. SIGNATURE Jack C. Lewis										22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Jack C. Lewis						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 11/65		23c. NAME OF CEMETERY OR CREMATORY ZION CEM.				23d. LOCATION (City, town or county) (State) BISHOPVILLE R.F.D. MD.			
24. FUNERAL DIRECTOR Anna A. Burbage Berlin Md.						25a. REC'D BY REGISTRAR DATE JAN 4 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

MEDICAL CERTIFICATION

1252X

1252X

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Worcester				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Worcester							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville				c. LENGTH OF STAY IN 1b lifetime				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Lee Tull				4. DATE OF DEATH 12 11 1965				5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8-18-1939				9. AGE (In years last birthday) 26 yrs.				IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY On farm				11. BIRTHPLACE (State or foreign country) Whaleyville		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Raymond Tull				14. MOTHER'S MAIDEN NAME Sarah Morris							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.				17. INFORMANT Constance Tull Address Whaleyville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wounds of head 976 x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Unstable mental condition instant DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted							
20c. TIME OF INJURY Month, Day, Year 9 a.m. 12-11-1965				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) Whaleyville				20g. (County) Wor.				20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Clifford E. Schott				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED			
EXAMINER'S NAME (Type) Clifford E. Schott, MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/14/65				23c. NAME OF CEMETERY OR CREMATORY Bethel			
23d. LOCATION (City, town or county) Hallards				23e. (State) Md.				25a. REC'D BY REGISTRAR DEC 20 1965			
24. FUNERAL DIRECTOR Telia Whaley Silby, Jr.				25b. REGISTRAR'S SIGNATURE Charles Judge							

20533

MEMORIAL EXAMINER OF DEATH

1910

1910

Worcester

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Worcester

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17198 CERTIFICATE OF DEATH 20580

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stockton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hebron (Rural) 22x 2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holland's Nursing Home		d. STREET ADDRESS R.D.# 1	
3. NAME OF DECEASED (Type or print) First HELEN Middle (NMI) Last TWILLEY		4. DATE OF DEATH Month DEC. Day 29 Year 1965	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23/1892
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 4 Days 6 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Laurel, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Roby W. Horsey		14. MOTHER'S MAIDEN NAME Kate Ellis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Paul H. Twilley (Husband) R.D.#1 Hebron, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMIPLEGIA DUE TO C.V.A. (OLD)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 10 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT 15 65 to DEC 29 65 , that (I) (we) last saw the deceased alive on DEC 28 1965 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Robert C. LaMar		22b. DATE SIGNED Dec. 31/1965	
22c. PHYSICIAN'S NAME (Type) Dr. Robert C. LaMar		22d. ADDRESS 104 N. Bay St. Snow Hill, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 31/1965	23c. NAME OF CEMETERY OR CREMATORY Mardela Memorial Cem.	23d. LOCATION (City, town or county) (State) Mardela, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR JAN 7 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

